California State Board of Pharmacy
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STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GRAY DAVIS, GOVERNOR

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CONSUMER COMPLAINT FORM

Please print or type PLEASE PROVIDE ALL THE REQUESTED INFORMATION

Name of Person Registering Complaint:				Name of Patient:	
Address: Number and Street	City		County	State	Zip Code
Work telephone number:	Home telephone number		Relationship to patient:		
Name of pharmacy:					
Address of pharmacy: Number and Street	City		County	State	Zip Code
Name of Pharmacist (if known):		Name of any other person involved:			
When did the problem occur?					

DETAILS OF COMPLAINT

Describe the events in the order they happened, as simply as possible. (Use extra sheets if necessary.)

Have you discussed this matter with the pharmacist? ☐ Yes ☐ No

Name of person contacted:	Date of contact:
How was contact made? ☐ By phone ☐ By letter ☐ In person	
Result of contact:	

FURTHER INFORMATION
(Complete only if applicable)

Prescribing doctor:	Telephone number:

Address of doctor: Number and Street	City	State	Zip Code

Medication prescribed:	Medication received:	Prescription Number:

The prescription was: ☐ for a new prescription ☐ a refill ☐ a new prescription for a medication taken or used previously

Was there harm to the patient? ☐ Yes ☐ No If yes, describe briefly:

Did the pharmacist consult with you regarding your medication at the time it was dispensed?	☐ Yes ☐ No
Was any of the medication taken or used?	☐ Yes ☐ No
Do you still have the medication?	☐ Yes ☐ No
Do you still have the container/label?	☐ Yes ☐ No

If you have the medication and/or container, please retain them until further notified by a board inspector.

If this complaint is against an individual licensed by the board of pharmacy, would you be willing to testify against the individual?

☐ Yes, I would be willing to testify ☐ No, I would not be willing to testify.

IF APPLICABLE, PLEASE ATTACH TO THIS FORM <u>COPIES</u> OF ANY PAPERS INVOLVED (prescription, bills/invoices received, cancelled checks, correspondence, etc.). DO NOT SEND ORIGINALS.

What outcome would you like as a result of this complaint?

READ CAREFULLY AND SIGN BELOW:

The information contained in this form is true, correct and complete to the best of my knowledge.

_____ _____

Signature **Date**